CERTIFICATE OF VISUAL EXAMINATION

TOP PORTION MUST BE COMPLETED BY APPLICANT

UTAH DRIVER LICENSE DIVISION

PO BOX 30560
SLC UT 84130-0560
PHONE NUMBER (801) 965-4437
FAX NUMBER (801) 288-5342
www.driverlicense.utah.gov

For Office Use Only:
☐ Private Vehicle Driver
☐ Commercial Vehicle Driver

Last Name **First Name** **Middle or Maiden Name** **Date of Birth** **Drivers License Number**

Street Address **City** **State** **Zip Code** **Social Security Number / ITIN**

☐ Address above is different from the address showing on my Driver's License.

By signing this form, I authorize my healthcare professional(s) to disclose specific health information regarding my physical, mental and emotional condition relevant to my ability to safely operate a motor vehicle, to the Utah Driver License Division, P.O. Box 30560, Salt Lake City, Utah 84130-0560. This authorization is valid for five years or the period of time needed to fulfill its purpose, whichever comes first. I also understand that I may revoke this authorization at any time, by sending written notification to the Utah Driver License Division at the above address.

I understand I may refuse to sign this Authorization. If I fail to sign this authorization my driving privilege may be affected. I understand that, once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by the federal medical law and could be re-disclosed by the person or agency that receives it. I understand that I may request a copy of this signed Authorization.

Date **Signature of Applicant (Required)**

EXAMINATION REPORT – (current within 6 months)

Visual Acuity **Lenses Required While Driving?**	**Without Correction** ☐ **NO**	**With Correction** ☐ **YES**	**Visual Field 120°** **60° to both right and left** **Private and Commercial** CDL COLOR BLIND ☐ YES ☐ NO
RIGHT EYE	**20/**	**20/**	☐ **YES** ☐ **NO**
LEFT EYE	**20/**	**20/**	☐ **YES** ☐ **NO**
BOTH EYES	**20/**	**20/**	☐ **YES** ☐ **NO**

Circle Profile Level: **1 2 3 4 5 6 7 8 9 10** Shaded areas require Medical Advisory Board review

Restrictions: ☐Speed ☐Area ☐ Daylight Only ☐Accompanied by Licensed Driver ☐ None

☐ YES ☐ NO If visual fields are less than 120°, are they at least 90°, with 45° to both the right and left of fixation?

☐YES ☐NO If visual fields are less than 90˚, are they at least 60˚, with 30° to both the right and left of fixation?

☐ I recommend this driver complete a driving skills test in an appropriate vehicle.

☐ YES ☐NO Does the patient have diabetes mellitus, cardiac disease, hypertension, or any other systemic disease that may affect driving?

Indicate the etiology of the visual impairment:_____

How stable is the visual condition? _____

Recommended interval for examination: ☐ Standard for Profile Level ☐ Other: Specify Interval_____

Date of Examination **Printed Name of Health Care Professional** **Signature and Degree** **State License Number**

Street Address **City** **State** **Zip Code** **Telephone** **Fax Number**

For Office Use Only:

DLD Screening

Date of Examination **Signature** **Employee Number** **Field Station**

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